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INFORMATION MEMO FOR AMBASSADOR RICHARD K. BELL, CÔTE D'IVOIRE

FROM: S/GAC – Acting U.S. Global AIDS Coordinator, Principal Deputy Assistant Secretary, Dr. Angeli Achrekar, DrPH, MPH

THROUGH: Julia Martin, Chair | Ann Sangthong, PPM

SUBJECT: Fiscal Year (FY) 2023 PEPFAR Planned Allocation and Strategic Direction

Dear Ambassador Richard K. Bell,

First and foremost, I sincerely hope that you and your team are safe and healthy. I am extremely grateful for your leadership of the PEPFAR program and additional COVID-19 response efforts during this difficult year.

While countries around the world continue to manage the effects of the COVID-19 pandemic, and the U.S. government acts on its commitment of support, it is encouraging to see vaccines making their way around the globe. The COVID response efforts – and continued use of the PEPFAR platform to support testing and vaccine delivery and uptake at point of care settings - are essential to our ability to provide ongoing care and life saving support for people living with HIV. The PEPFAR program has faced many challenges as a program during this period. Nevertheless, the PEPFAR family and partners have carried the mission forward while enduring significant personal impacts of COVID-19. Despite these challenges, what remains true is the strength and resilience of PEPFAR in partnership with countries and communities – through our teams, and our programs in the midst of dueling pandemics.

Tremendous effort has been made by PEPFAR over the year to protect and accelerate the HIV gains, while leveraging the platform to respond to COVID-19 as well.

PEPFAR Country Operational Plans (COP 2022 for implementation in FY2023) represents a pivotal year in PEPFAR, as several countries are reaching or approaching the agreed upon UNAIDS 95/95/95 benchmarks for attaining epidemic control. As all countries work towards these benchmarks and some pivoting from “scaling to close gaps” to “sustaining” epidemic control, we must ensure HIV program and population equity address outstanding barriers that threaten to derail progress made in reducing new HIV infections and associated mortality, and tailor programs to serve all populations.

This year it is particularly important to plan COP together with the country government, civil society, and multilateral partners. Across PEPFAR, the focus on equity requires vigilant attention to program data demonstrating results and gaps. A focus on equity also means a focus on population groups where our efforts to date have not closed gaps, and specific planning, resource allocation, and program tailoring are

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needed – depending on what the data reveal for each country – focusing on: children, adolescent girls and young women, and key populations.

While most PEPFAR countries are on a path to achieving program coverage goals, PEPFAR programs should focus on four key themes as we approach COP 22 planning and implementation:

1. Achieve and sustain epidemic control using evidence-based, equitable, people-centered HIV prevention and treatment services.
2. Support resilient and capacitated country health systems, communities, enabling environments, and local partners to build enduring capabilities.
3. Strengthen cooperation and coordination for greater impact, burden sharing, and sustainability.
4. Employ an equity lens with a persistent focus on reducing persistent inequalities experienced by children, key populations, and adolescent girls and young women.

I want to applaud the PEPFAR team for:

- The successful policy implementation of TLD as first line ART for all adults including women of all ages resulting in 85% of the adult treatment cohort now receiving WHO recommended first line HIV treatment therapy. Similarly, rapid adoption and implementation of DTG10mg regimens for HIV positive children weigh less than 20 kg.
- Growth in viral load coverage and improvement in viral suppression both achieving high levels and showing strong progress to the VLC and VLS data continue to progress well towards the desired 95% goal.
- Strong growth in multi-month dispensing (86% of the treatment cohort), and particularly the shift to 43% receiving MMD 6 months.

Together with the Government of Côte d'Ivoire and civil society leadership we have made tremendous progress together. Côte d'Ivoire should be proud of the progress made over the past 18 years of PEPFAR implementation and we are deeply grateful for the ongoing coordination with the Global Fund and UNAIDS.

As you will see in COP guidance this year, changes in program direction will vary depending on where countries are in reaching epidemic control and the continued COVID-19 mitigations efforts each team is facing. While assessing possible shortfalls in programming arising from COVID-19, overarching challenges still exist. Specifically, more focus and attention should be given to the following key challenges in PEPFAR Côte d'Ivoire:

- Slow growth of the treatment cohort and interruption in treatment across multiple age and sex bands; men particularly affected.
- Significant delays in scale up in TB/HIV treatment and TB preventative therapy and policy barriers to implementation of PrEP in all target populations.
- Commodity stock management with risks to viral load reagent and ARV security.

A fuller set of details, including funding earmarks and specific program direction are included in the accompanying COP 22 PEPFAR Planned Allocation and Strategic Direction Summary.

Consistent with the approach from years past, PEPFAR teams will once again be responsible for setting their own targets across PEPFAR program areas (with the treatment current target no less than the result that was to be achieved in COP 2021) in consultation with stakeholders. Teams should bear in mind that PEPFAR targets are not PEPFAR's but flow directly from the partner country government's commitment to the UNAIDS and SDG 3 goals.

The PEPFAR COP 22 notional budget for Côte d'Ivoire is **\$105,000,000** inclusive of all new funding accounts and applied pipeline. All earmarks and program directives provided below must be met. Targets and the subsequent approved budget should reflect the level of ambition the PEPFAR team, in collaboration with the Government of Côte d'Ivoire and civil society of Côte d'Ivoire, believes is critical for the country's progress towards controlling the pandemic and maintaining control.

Finally, in alignment with efforts by the U.S. government to support diversity, equity, inclusion, and accessibility as well as to advance equity for underserved communities and prevent and combat discrimination or exploitation on the basis of race, religion, gender identity or sexual orientation, PEPFAR will work to ensure that these principles are upheld, promoted, and advanced in all PEPFAR programs and in how we do business.

Please note that within the next few days our PEPFAR Chairs and PEPFAR Program Managers (PPMs), working closely with our CAST teams, will review this planning letter and details contained, herein, with your wider PEPFAR country team. Stakeholder engagement is essential for a productive and impactful planning process, and civil society engagement will continue to be an integral part of this planning process. Included in this planning letter is an outline of the expectations for engaging key stakeholders and civil society, as we continue to finalize our approach to hosting a virtual COP22 planning and approval process.

Once again, thank you for your continued leadership and engagement during the COP22 process.

Sincerely,

Angeli Achrekar

Attachment: **COP/ROP 2022 PEPFAR Planned Allocation and Strategic Direction Summary.**

CC: S/GAC – Julia Martin, Chair | Ann Sangthong, PPM
Bibola Ngalamulume, PEPFAR Country Coordinator

Overview: COP 2022 PEPFAR Planned Allocation and Strategic Direction

With input from the field teams through the quarterly monitoring POARTs, as well as Headquarters Country Accountability and Support Teams (CAST) input, a thorough program review of your country over time has been conducted. This includes the end of year results of the Country Operational Plan (COP) 2020 and current COP 2021 implementation as we plan for COP 2022. We have noted the following key successes and challenges.

Successes

While the COVID-19 induced unpredictability and challenges of 2020 and 2021 were at times difficult to manage, PEPFAR Côte d'Ivoire has stayed the course, protecting advances in the national HIV response and adapting positively to changing context. The PEPFAR team, Government of Côte d'Ivoire (GOCI) and all of the partners must be applauded for some excellent results in a complex time, and for using the COVID-19 circumstances to advance service delivery policies that have made HIV prevention and treatment more client-focused and quality driven.

The importance of offering the most optimal ARV regimens cannot be emphasized enough. After slow progress on adopting and implementing TLD for men and women (of all ages), FY2021 saw a seismic jump in coverage with the proportion of women now receiving TLD at 82% and with an overall treatment cohort TLD achievement of 85%. By FY21, viral load suppression had reached 91% with anticipated further improvement with the switch to TLD in all populations. Similarly, **with the adoption of DTG 10mg for pediatric HIV treatment**, the transition to use of this regimen for children and infants under 20kg has been rapid, with 39% to 89% of the cohort prescribed DTG 10mg based regimen. Correspondingly, real improvements in viral load suppression followed the transition to DTG 10mg.

Treatment delivery also adapted in response to COVID-19 and the program saw major gains in offering multi-month dispensing (MMD) across all age bands. As of FY21 Q4, 86% of the treatment cohort was receiving MMD including 43% receiving 6MMD.

Pregnant women continued to receive quality PMTCT services with high HIV testing coverage and significant improvements in viral load coverage and suppression. Early Infant Diagnosis (EID) and linkage to ART saw strong improvements with gains made through mother-infant pair referrals to the OVC program, active tracking of pregnant women, and deployment of point-of-care testing.

For program and services for children and AGYW, strong progress was also made in FY21. DREAMS primary package completion by all age bands showed strong results, in part owing to adaptations made in accessing these populations during COVID-19 restrictions. The OVC program reported excellent results including improvements in the percentage of the cohort with a known HIV status, number of HIV positive children enrolled and expanding collaboration with clinical partners. \

From a health systems perspective, PEPFAR Côte d'Ivoire continued to build on many years of technical and financial investment in health information systems to support the country improve program data quality and management of the HIV epidemic. Important progress was made with the patient management systems (SIGDEP) and introducing a unique client identifier as well as systems already established (SIGSANTE).

Lastly, it is important to recognize the efforts of PEPFAR Côte d'Ivoire in strengthening relationships the GOCI on planning and service delivery. Policy discussion and adoption have led to significant improvements in results and ultimately health outcomes for people served.

Challenges

While changes have been made to the HIV testing program and index testing has increased, **the overall testing strategy is not yet sufficiently focused on specific populations and age bands.** Provider initiated testing remains the primary testing modality and while it results in the largest number of HIV positive persons identified, significant testing is required to identify positives. Progress in index testing should remain a focus for improvement. HIV testing among pediatric cases had limited results with sub-optimal implementation of the screening tool.

The HIV treatment cohort experienced slow growth in FY21. Interruption in treatment remained a challenge particularly among 30-50 year olds (males and females) and significant interruption experienced in those persons on treatment for less than three months among 15-34 year olds. Helpful analysis of data by the PEPFAR team indicates that 60% of interruptions come from 23 facilities. Deaths also contribute to interruption in treatment likely attributed to an aging HIV epidemic with inadequate HIV treatment and treatment of comorbidities. Men lag in return to treatment efforts and overall, significant gaps in men on treatment persist. While there were positive gains made in MMD, options for community ART delivery have been slow to expand with small proportions of the treatment cohort enrolled in alternative forms of ART access. Client centered approaches must increase in focus in COP22.

Progress in TB/HIV treatment and prevention is slow with 12% of targets achieved for TPT and approximately 4% of persons enrolled in the treatment cohort having completed a course of TPT. While rates of TPT completion are high, the number of persons initiated is extremely low.

PrEP scale-up remains slow. Policy and implementation barriers remain, creating significant challenges to offering PrEP and acceptance by populations that could benefit from this prevention intervention. PrEP new achievement was 33% and PrEP current achievement 29%.

Commodity stock management and transparency has presented challenges to program delivery, EID/viral load reagents in particular. Despite availability of national plans and participation in service level agreements, long periods of viral load reagent stock outs were experienced, and equipment maintenance issues further impeded sample processing. TLD-30 overconsumption created stock imbalances for TLD-90 and TLD-180 owing to provider discomfort with TLD-90 bottles. Commodity risks persist in FY22 with uncertainty of budget coverage for the full complement of ARVs and lab reagents required for COP21 implementation.

Stigma remains high and creates barriers to access to prevention and treatment services.

Given your country's status of near achieving epidemic control, the following priority strategic and integrated changes are recommended:

Services:

1. Revisit and refine overall testing strategy with sub-strategies for specific populations - in particular for men and pediatrics. PITC inefficiencies (high number of tests performed) need to be addressed and index testing should focus on approaches to growing the number of contacts provided from the initial test positive cases. For regions other than Abidjan, identify those with performance issues resulting in part from sub-optimal inter-partner collaboration between facility and community.

2. **Scale PrEP in priority populations (key populations, men, AGYW).** Address testing policy barriers to PrEP implementation with support from WHO (CDI, regional, HQ) and advocacy to the GoCI for buy-in to de-medicalizing implementation.

3. **Focus reducing TB morbidity and mortality** among HIV treatment cohort with approaches to testing and offer of TPT.

Populations:

4. **Close the treatment gap in men.** Building from a clear HIV testing approach for men based on age bands, ensure linkage to treatment and client centered approaches to treatment delivery that retain men in care and successfully return those whose treatment has been interrupted.

5. **Refine and/or develop a comprehensive approach to pediatric care and treatment.** This should include: ongoing leveraging of the OVC platform; strengthen family case management; and maximize mPIMA instruments to scale-up point-of-care early infant diagnosis.

6. **Increased attention to comprehensive programming for key populations and AGYW.** Focus on Key Population cascade for linkage and treatment continuity. Strengthen the DREAMS focus on prevention of HIV and sexual violence at the community level and increase support for education and comprehensive economic strengthening.

Systems:

7. **Support efficient patient-centered care within GoCI health delivery architecture and management.** Examine and improve efficiencies to strengthen quality of care and delivery of patient-centered services in national health system, and simplify models of service delivery that fully align with and can be ultimately supported by the GoCI.

8. **Strengthen systems and approaches in efficient program delivery and partner management.** For COP22, districts in Abidjan only will be rationalized under CDC and USAID with a single comprehensive service delivery partner per district. More than one partner can be utilized per Agency, however, more than two partners per Agency for the Abidjan region will require justification. In and outside of the Abidjan region, a common approach to partner management must be instituted across all agencies with a required ‘fidelity of approach to service delivery’ by all partners. The PEPFAR interagency team should maximize exchange of innovations and positive outcomes to improve program quality across the program.

9. **Health information systems activities should continue to advance aligned with and under the leadership of the GoCI.** System development must have defined and cross-agency buy-in on requirements, and deployment must have undergone rigorous end-user testing. Interoperability with existing GoCI systems must be prioritized.

SECTION 1: COP 2022 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2021 (EOFY) tool, and performance data, the total COP 2022 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by your agency.

TABLE 1: All COP 2022 Funding by Appropriation Year

	Bilateral				Central				Total
	FY22	FY21	FY20	Unspecified	FY22	FY21	FY20	Unspecified	TOTAL
Total New Funding	\$ 98,883,899	\$ -	\$ -	\$ -	\$ 750,000	\$ -	\$ -	\$ -	\$ 99,633,899
GHP-State	\$ 97,108,899	\$ -	\$ -		\$ -	\$ -	\$ -		\$ 97,108,899
GHP-USAID	\$ -				\$ 750,000				\$ 750,000
GAP	\$ 1,775,000				\$ -				\$ 1,775,000
Total Applied Pipeline	\$ -	\$ -	\$ -	\$ 5,366,101	\$ -	\$ -	\$ -	\$ -	\$ 5,366,101
DOD				\$ 782,689				\$ -	\$ 782,689
HHS/CDC				\$ 1,835,494				\$ -	\$ 1,835,494
USAID				\$ 1,494,640				\$ -	\$ 1,494,640
USAID/WCF				\$ 1,253,278				\$ -	\$ 1,253,278
TOTAL FUNDING	\$ 98,883,899	\$ -	\$ -	\$ 5,366,101	\$ 750,000	\$ -	\$ -	\$ -	\$ 105,000,000

SECTION 2: COP 2022 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

Countries should plan for the full Care and Treatment (C&T) level of \$62,000,000 and the full Orphans and Vulnerable Children (OVC) level of \$17,593,800 of the PLL across all funding sources. These earmark levels on new funding are subsets of those amounts that must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

TABLE 2: COP 2022 Earmarks by Appropriation Year*

	Appropriation Year			
	FY22	FY21	FY20	TOTAL
C&T	\$ 62,000,000	\$ -	\$ -	\$ 62,000,000
OVC	\$ 17,593,800	\$ -	\$ -	\$ 17,593,800
GBV	\$ 1,460,200	\$ -	\$ -	\$ 1,460,200
Water	\$ 318,000	\$ -	\$ -	\$ 318,000
<i>*Only GHP-State and GHP-USAID will count towards the earmarks (Care and Treatment, OVC, GBV, and Water).</i>				
<i>**Only GHP-State will count towards the GBV and Water earmarks</i>				

TABLE 3: COP 2022 Initiative Controls: Each dollar planned in COP can belong to only one initiative. Most COP funding will be budgeted as Core Program. In general, initiatives other than Core Program are used to track activities/programs that cannot be tracked by the combination of program area and beneficiary alone. See Appendix 1 for more detailed information on initiatives.

	Bilateral	Central	TOTAL
Total Funding	\$ 104,250,000	\$ 750,000	\$ 105,000,000
Core Program	\$ 83,576,800	\$ -	\$ 83,576,800
Condoms (GHP-USAID Central Funding)	\$ -	\$ 750,000	\$ 750,000
DREAMS	\$ 16,000,000	\$ -	\$ 16,000,000
OVC (Non-DREAMS)	\$ 4,673,200	\$ -	\$ 4,673,200

TABLE 4: Programmatic Controls: Programmatic controls are used to track programmatic directives that can be tracked by a combination of program area and/or beneficiary. Programmatic controls may overlap with Initiatives, for example PrEP for Adolescent Girls and Young Women may count towards both the DREAMS Initiative and the PrEP (AGYW) programmatic control. See Appendix 1 for more detailed information on programmatic controls.

	Bilateral	Central	TOTAL
Total Funding	\$ 594,600	\$ -	\$ 594,600
PrEP (AGYW)	\$ -	\$ -	\$ -
PrEP (KPs)	\$ 594,600	\$ -	\$ 594,600

TABLE 5: State ICASS Funding

	Appropriation Year
	FY22
ICASS	\$ 119,661

See Appendix 1 for detailed budgetary requirements and other budgetary considerations.

SECTION 3: PAST PERFORMANCE – COP 2020 Review

TABLE 6. COP OU Level FY21 Program Results (COP20) against FY22 Targets (COP21)

Indicator	FY21 result (COP20)	FY22 target (COP21)
TX Current <15	8,488	13,576
TX Current 15+	233,622	262,724
VMMC >15	NA	NA
DREAMS (AGYW PREV)	69,057	53,826
Cervical Cancer Screening	NA	NA
TB Preventive Therapy	8,938	213,200

TABLE 7. COP 2020 | FY 2021 Agency-level Outlays versus Approved Budget

OU/Agency	Sum of Approved COP/ROP 2020 Planning Level	Sum of Total FY 2021 Outlays	Sum of Over/Under Outlays
OU			
DOD	\$3,384,787	\$3,284,690	\$100,097
HHS/CDC	\$58,752,982	\$56,405,448	\$2,347,534
HHS/HRSA	\$800,000	\$720,000	\$80,000
State	\$586,357	\$535,169	\$51,188
USAID	\$38,189,971	\$32,549,174	\$5,640,797
USAID/WCF	\$15,370,951	\$14,422,086	\$948,865
Grand Total	\$117,085,048	\$107,916,567	\$9,168,481

TABLE 8. COP 2020 | FY 2021 Results & Expenditures

TABLE 6: COF 2020 FY 2021 Results & Expenditures							
Agency	Indicator	FY20 Target	FY20 Result	% Achievement	Program Classification	FY20 Expenditure	% Service Delivery
HHS/CD C	HTS_TST	1,400,487	1,096,774	78.31%	HTS Program Area	\$5,982,662	98%
	HTS_TST_POS	60,853	27,250	44.78%	HTS Program Area	\$5,982,662	98%
	TX_NEW	68,506	28,615	41.77%	C&T Program Area	\$22,445,503	96%
	TX_CURR	345,264	234,026	67.78%	C&T Program Area	\$22,445,503	96%
	VMMC_CIRC						
	OVC_SERV	53,254	64,070	120.31%	OVC Beneficiary	\$1,488,288	100%
DOD	HTS_TST	14,759	9,135	61.89%	HTS Program Area	\$23,664	100%
	HTS_TST_POS	1,182	905	76.57%	HTS Program Area	\$23,664	100%
	TX_NEW	1,126	807	71.67%	C&T Program Area	\$1,379,616	80%
	TX_CURR	5,795	4,395	75.84%	C&T Program Area	\$1,379,616	80%
	VMMC_CIRC						
	OVC_SERV				OVC Beneficiary	-	-
USAID	HTS_TST	114,792	71,609	62.38%	HTS Program Area	\$4,053,074	99%
	HTS_TST_POS	11,864	5,335	44.97%	HTS Program Area	\$4,053,074	99%
	TX_NEW	1,385	1,509	108.95%	C&T Program Area	\$17,589,547	100%
	TX_CURR	6,785	3,689	54.37%	C&T Program Area	\$17,589,547	100%
	VMMC_CIRC						
	OVC_SERV	179,071	198,411	110.80%	OVC Beneficiary	\$4,292,276	100%
					Above Site Programs	\$4,252,052	
				Program Management	\$18,583,223		

SECTION 4: COP 2022 DIRECTIVES

The following section has specific directives for COP 2022 based on program performance noted above. Please review each section carefully including the minimum program requirements.

Minimum Program Requirements (MPR)

All PEPFAR programs – bilateral and regional– must ensure the following minimum program requirements are in place. Adherence to these policies and practices is essential to the success of all PEPFAR programs at the national, subnational, and service delivery levels (e.g., facility, school, community). Evidence demonstrates that lack of any one of these policies/practices significantly undermines HIV impact and results in inefficient and ineffective programs.

All PEPFAR programs are expected to meet all of the requirements below, and the COP22 Planning Meeting will include a review of the status of each requirement, including assessment of implementation (including barriers) at the point of client services. To the extent that any requirement(s) have not been met by the time of the COP22 Planning Meeting, the PEPFAR OU team will need to present a detailed description of existing barriers and the remediation plans proposed that will allow them to meet the requirement(s) prior to the beginning of FY2023. The list will be included in the Strategic Direction Summary (SDS), as well.

Failure to meet any of these requirements by the beginning of FY2023 may affect the OU budget. The minimum requirements for continued PEPFAR support include the table below.

TABLE 9. COP/ROP 2022 (FY 2023) Minimum Program Requirements

Care and Treatment	
1.	Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups. <u>Status:</u> Completed
2.	Rapid optimization of ART by offering TLD to all PLHIV weighing ≥ 30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥ 4 weeks of age and weigh ≥ 3 kg, and removal of all NVP- and EFV-based ART regimens. <u>Status:</u> In-process (anticipated date of completion, Q4 COP21) <u>Issues or Barriers:</u> Suboptimal TLD prescribing for pregnant women and women of reproductive years. Site-level stock availability and management of ARVs needs improvement. Standardization of community ARV distribution models need improvement. Despite challenges, significant progress observed through the increase of children on DTG-based regimens from Q1 (39%) to Q4 (89%), reduction of children on EFV-based regimens by over 80% from 18% in Q1 to 3% in Q4, and PEPFAR has provided 100% DTG-based regimens for children in FY22.
3.	Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups. <u>Status:</u> In-process (anticipated date of completion improvements through COP21) <u>Issues or Barriers:</u> Challenges with stock and ARV distribution in the community, but COVID adaptations have bolstered the acceleration of MMD, primarily 6MMD, across all age groups.
4.	All eligible PLHIV, including children and adolescents, should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient. <u>Status:</u> In-process (slow update in FY21 with uncertainty FY22 – timeline for completion not on target) <u>Issues or Barriers:</u> Suboptimal TPT initiations. Challenges: Lack or limited engagement of providers in offering TPT to patients; and management of commodities from the central pharmacy warehouse to health facilities.

<p>5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.</p> <p><u>Status:</u> In-process (anticipated date of completion TBD)</p> <p><u>Issues or Barriers:</u> DNO activities had been on hold until COP21 funding was confirmed through ARPA. The team is collaborating with Global Fund, GoCI, other national laboratories, and partners, on DNO activities with defined phases per partner. The initial phase supported by Global Fund was delayed due to COVID.</p>
Case Finding
<p>6. Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.</p> <p><u>Status:</u> In-process (anticipated date of completion – ongoing implementation of index testing)</p> <p><u>Issues or Barriers:</u> Pause and drop in results for index testing due to COVID. Considerable variability on self-testing yield among partners with similar volumes suggest variability in approach (to be addressed). Team has assessed and taken action when RedCap assessments of IPV programs identified need for SOPs, training/refreshers and improvement plans for CCs.</p>
Prevention and OVC
<p>7. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)</p> <p><u>Status:</u> In-process (ongoing implementation)</p> <p><u>Issues or Barriers:</u> Low PrEP demand creation. Policy barriers are impeding scale up: only physicians are authorized to initiate PrEP despite the option of task-shifting; the policy requires a hepatitis B Ag renal function lab test required to initiate PrEP; and reagents for this lab test are not consistently available/free. Issues with MOH/DIEM-led laboratory equipment maintenance.</p>
<p>8. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.</p> <p><u>Status:</u> In-process (implementation ongoing)</p> <p><u>Issues or Barriers:</u> Need to continue accelerating C/ALHIV enrollment to improve OVC proxy coverage of TX_CURR<15 y/o and <20 y/o, prioritizing districts with <80% proxy coverage. Lack of routine data reviews between OVC and clinical partners to collaboratively monitor index testing and C/ALHIV and HEI outcomes. Move to mandated sharing of patient-specific data from the clinical partners to the OVC partners. A family-centered care model for enrolled households with multiple PLHIV/CLHIV to further support continuity of care and wraparound services for enrollees needs to be established.</p>

Policy & Public Health Systems Support

9. In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.
Status: In-progress (ongoing)
Issues or barriers: Challenges include: self-stigmatization of patients, stigmatization by health providers, and poor knowledge of patients' rights. The results of the recent Stigma index compared to those of the Index Stigma 1.0 study carried out in 2016 show that many indicators have improved, but situations of stigma and / or discrimination and self-stigma persist. Patient literacy activities are ongoing at all supported sites and providers are receiving coaching and refreshers from PEPFAR. In collaboration with MoH/PNLS, training sessions in March 2022 will cover a KP-friendly services approach for the benefit of 80 actors from 33 facilities that offered services to at least 3 KPs during FY2021.
10. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP, and routine clinical services affecting access to HIV testing and treatment and prevention.
Status: In-process (Completed but now in status of confirmation of practice)
Issues or Barriers: Need to continue discussions with CSOs to ensure policies are implemented with fidelity and new data will be collected as part of recently launched CLM activities.
11. OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.
Status: In-process (implementation on-going)
Issues or Barriers: No issues of note. Partners continue to share best practices and results with the GoCI, who is also working on CQI in assigned areas.
12. Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other partner country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.
Status: In-process (implementation on-going)
Issues or Barriers: Issues related to patient literacy is being addressed at site level, and messages of hope have been developed and ready for dissemination in collaboration with the faith community in Q2. Continued efforts to adjust counseling message at 100% sites and health districts.
13. Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses.
Status: In-process (implementation on-going and commensurate with capacity)
Issues or Barriers: Financial resources and technical capacity building are needed per assessments from agencies.

<p>14. Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.</p> <p><u>Status:</u> In-process (on-going)</p> <p><u>Issues or Barriers:</u> There is a need for more timely procurement, maintenance, and service level agreement support for commodities. Inadequate procurement forecasting also hinders reliability of procurement responsibilities per the common basket approach. SID21 data suggests greater domestic resource mobilization is needed with increased responsibility; advocacy for increased domestic resource mobilization is an ongoing effort.</p>
<p>15. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.</p> <p><u>Status:</u> In process (uncertain timeline)</p> <p><u>Issues or Barriers:</u> Two significant causes of TX_ML deaths is death from an unknown cause (53.69%) and other natural causes (37.59%). Results for an ongoing study will need to be disseminated widely to understand the causes of death among PLHIV and potentially inform programmatic realignment. Need to explore discussions with MOH and other stakeholders on integration of chronic disease management with HIV services to address high mortality from other causes. Need to continue strategic investment in the management of advanced HIV morbidity, including advanced disease for adults, children, and adolescents.</p>
<p>16. Scale-up of case surveillance and unique identifiers for patients across all sites.</p> <p><u>Status:</u> In-process (timeline for completion TBD)</p> <p><u>Issues or Barriers:</u> Additional financial resources and related training, human resources, necessary to successfully establish across all sites.</p>

In addition to meeting the minimum requirements outlined above, it is expected that Côte d'Ivoire will consider all the following technical directives and priorities. A full list of COP 2022 Technical Priorities and Considerations are listed in COP guidance and can be referenced in Section 6.

Table 10. COP 2022 (FY 2023) Technical Directives

Côte d'Ivoire –Specific Directives
<i>HIV Clinical Services</i>
1. Close the testing and treatment gap for men through a differentiated service delivery strategy and strengthen models to optimize case finding, linkage to, and continuity of treatment among men.
2. Establish a comprehensive approach for pediatric HIV/AIDS through a differentiated service delivery strategy and adapt models to optimize case finding, linkage to, and continuity of treatment.
3. Leverage OVC to improve C/ALHIV and HEI outcomes and strengthen/establish family case management.
4. Maximize mPIMA instruments in country to scale-up point-of-care early infant diagnosis.
5. Continue to scale up peds ARV optimization to improve pediatric VLS.
6. Review the differentiated service delivery strategy for vulnerable populations, including AGYW and KP, and adapt models to optimize case finding, linkage to and continuity of treatment, to address the unique needs.
7. Utilize country data to develop a clear, targeted and population-specific differentiated testing strategy that optimizes index and PITC testing.

8. Improve quality of TB symptom screening and maximize TB diagnostics through the utilization of the 27 GeneXperts in country, LF-LAM, and other molecular tests.
9. Reserve community outreach for tracking HIV treatment clients who have treatment interruptions; stop home visits for stable patients and advocate to update national guidelines accordingly.
<i>HIV Prevention Services</i>
1. PrEP for KP, AGYW and men: In COP 2022, PrEP should continue to be scaled up with a focus on ensuring policy and programmatic access to PrEP for higher incidence populations. Populations prioritized for PrEP should be tailored to CDI's epidemic context with a focus on Key Populations (including sex workers, men who have sex with men, transgender people, people in prisons and other closed settings, people who inject drugs), adolescent girls and young women including pregnant and breastfeeding AGYW, and other identified higher-incidence populations (men).
2. Strengthen the DREAMS program focus on prevention of HIV and sexual violence at the community level and increase support for education and comprehensive economic strengthening. Include PrEP as part of program scale-up.
3. Work with PNLS and WHO to update and finalize the national guidance to align with WHO normative guidance on PrEP. National guidance needs to reflect clinical monitoring requirements, allow for flexible, client-centered services, and more inclusive language to reduce any potential stigmatization of PrEP and/or populations.
4. Invest in demand creation strategies and materials to normalize PrEP.
5. Expand PrEP services in the community and with vulnerable populations such as pregnant and breastfeeding women. Explore how new PrEP products could be implemented.
6. Strengthen efforts to accelerate scale-up of TPT among PLHIV – offer of TPT in particular.
<i>Other Government Policy, Systems, or Programming Changes Needed</i>
1. Examine and improve efficiencies to strengthen quality of care and delivery of patient-centered services in the national health system; simplify models of service delivery and ensure consistent practices across partners irrespective of USG Agency overseeing partner.
2. Continue the exchanging best practices among partners, GoCI, and CSOs to maximize efficiencies and ensure alignment with government health service delivery design. For PEPFAR programs that have met targets in COP20, partners should continue or initiate closer engagement with the GoCI staff at the central, regional, and district level, so that GoCI is able to independently manage and implement programs over time.
3. Harmonize and continue to advance health information systems (for community and facility service delivery) to more effectively triangulate clinical and community services data, facilitate improved client tracing, follow-up, and support patient-centered care. The HIS TWG to develop a 3- to 5-year workplan and monitor key activities.
4. Support the partner geographic rationalization and transition in Abidjan with intensified (Abidjan-centric) partner management in the shift to single comprehensive partner per district in COP22.
5. Intensify partner management support for community-facility collaboration to more effectively manage patients and optimize client outcomes.
6. Leverage COP21 HRH Inventory data to improve program efficiencies and adjust staffing levels (reduce, increase) as needed to deliver quality services.
7. Continue efforts to strengthen supply chain management, transparency, and forecasting, in coordination with the Global Fund, PNLS, NPSP, and partners. Strengthen engagement with MOH DIEM on service level agreements for all PEPFAR-procured equipment. New procurements (equipment, facility/lab fabrications) must be clearly delineated in the COP22 plan.
8. Strengthen capacity of local/indigenous partners, particularly in six areas including legal structure, financial management and internal control, procurements system, and human resources and organization sustainability, to support local program ownership.
9. Structural barriers for KP: COP 22 plans should prioritize and take specific steps to address the structural barriers that impede scale up of KP-led and KP-competent differentiated HIV services, as

well as the lack of robust data to guide key populations programming. To strengthen strategic information to guide KP responses, plans may include efforts to strengthen individual level data systems and analyses and address gaps in subnational data. Addressing structural barriers should entail improving the enabling environment for HIV service delivery; mitigating harmful policy and social norms that fuel stigma, discrimination and violence faced by key populations; strengthening the capacity of key populations organizations; and strengthening the KP competency of HIV service providers. PEPFAR teams should ensure they are coordinating strategically with relevant State and U.S. government units (e.g., DRL), partner government, multilateral, and other donor funding streams and institutions. As part of the new COP 22 MPR, PEPFAR teams will be expected to describe and present their approach to improving KP data and addressing barriers to accelerated KP-centered HIV services during COP22 planning meetings

10. HIV-related stigma and discrimination: Cote d'Ivoire has been selected to participate in the focal countries collaboration, an effort among the Global Fund, UNAIDS and PEPFAR to measurably reduce stigma and discrimination through increased coordination, collaboration and planning with communities, governments, and national partners, in a set of focal countries over a 3-5 year period. The focal countries collaboration will help advance efforts toward meeting the 10-10-10 societal enabler targets and PEPFAR's minimum program requirement #9, and will build upon existing initiatives, activities and coordinating mechanisms. As an initial step, PEPFAR teams are requested to work with partners to convene a meeting during the strategic planning meeting window (January 24th - February 11) to take stock of key opportunities to advance national efforts to address HIV-related stigma and discrimination, such as, as applicable, national strategic plans, settings prioritized under the Global Partnership For Action to Eliminate All Forms of HIV-Related Stigma and Discrimination, new evidence provided by the PLHIV Stigma Index 2.0 and GF Breaking Down Barriers mid-term assessments. It is expected that such stock taking will inform coordinated action in funding and implementing [comprehensive programmatic strategies](#) to reduce stigma and discrimination at scale and promote partner government and community leadership at the country level.

COP 2022 Active Engagement with Community and Civil Society (see section 2.5.3 of COP Guidance)

The full participation of community stakeholders and civil society in every stage of PEPFAR programming, planning, and monitoring, as appropriate and consistent with applicable law, regulations and policy, from advocacy to service delivery, is critical to the success and sustainability of PEPFAR and the global effort to combat HIV. Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional, and international civil society and community stakeholders, multilateral partners and the partner country government.

Civil society organizations are essential and to be invited to participate in the virtual COP22 strategic retreats, planning meetings, as well as approval meetings. In particular, engagement with local CSOs at the country-level is required and should begin early and continue during the entirety of the COP planning, monitoring, and implementation process.

This engagement of civil society, including faith-based organizations/faith communities, specifically includes the sharing of FY 2021 Q4 and FY 2021 Annual Program Results (APR), analyses, and the convening of an in-country planning retreat with local stakeholders, no later than the week of February 7, 2022, in order to introduce and discuss all COP/ROP 2022 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 2022. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund, with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In March 2022, PEPFAR will convene virtual meetings where outstanding decisions will be discussed and finalized. In addition to partner country representatives, the meetings will also include representatives from local and international civil society and community organizations, faith-based organizations/faith communities, private sector, and multilateral partners. Specific guidance for the 2022 virtual meeting delegations will be provided separately.

Engagement with all stakeholders is required beyond the meetings and throughout COP/ROP 2022 development, finalization, and implementation. As in COP/ROP 2021, the draft Strategic Direction Summary (SDS) is required to be shared with both CSO and FBO stakeholders for their input and comments at least 7 days prior to submission to S/GAC. Please refer to the COP/ROP 2022 Guidance for a full list of requirements and engagement timelines. In addition, a more detailed timeline for sharing key data visualizations and other information with stakeholders is forthcoming.

Community-led Monitoring (CLM)

In addition to prescribed and routine engagement during PEPFAR's annual business cycle, including around COP/ROP planning and quarterly POART processes, all PEPFAR programs are required to develop, support, and fund community-led monitoring (CLM) in close collaboration with independent, local civil society organizations and host country governments. Community-led monitoring in COP22 should build on prior activities in COP21 and be designed to help PEPFAR programs and health institutions pinpoint persistent problems, challenges, barriers, and enablers to effective client outcomes at the site level. In addition to being data-driven and action-oriented, CLM should continue to ensure indicators are defined by communities and health service users, and data should be additive and not a duplicate collection of routine data already available to PEPFAR through MER or SIMS. New in COP22, PEPFAR-supported community-led monitoring programs must include an explicit focus on key populations. CLM should be utilized to advance equity and to support improvement in programs, especially for populations who have not yet fully experienced the benefits of HIV epidemic control. For example, OUs with pediatric care and treatment programs should consider utilizing CLM to track and ensure accountability for child, adolescent, and family-centered care.

APPENDIX 1: Detailed Budgetary Requirements

Care and Treatment: Each OU's COP/ROP 2022 minimum requirement for the care and treatment earmark is reflected in Table 2. If there is no adjustment to the COP/ROP 2022 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment earmark amount across new FY 2022 GHP-State and GHP-USAID funding. The Care and Treatment earmark will be calculated as the sum of the following:

- ♦ 100% Care and Treatment (C&T) Program Areas
- ♦ 50% Testing (HTS) Program Areas
- ♦ 100% Above Site Program: Laboratory System Strengthening
- ♦ 70% Pregnant and Breastfeeding Women Beneficiary Group
- ♦ Proportional % Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the C&T earmark)

Orphans and Vulnerable Children (OVC): Each OU's COP/ROP 2022 minimum requirement for the OVC earmark is reflected in Table 2. Countries must program to the full OVC earmark amount across new FY 2022 GHP-State and GHP-USAID funding. The OVC earmark will be calculated as the sum of the following:

- 85% (DREAMS initiative funding — commodities planned under DREAMS initiative — Any HTS interventions planned under DREAMS initiative — Any C&T intervention planned under DREAMS initiative)
- 100% (OVC Beneficiary group funding — commodities planned under any intervention with OVC beneficiaries — Any HTS planned under interventions with OVC beneficiaries)
- Proportional Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the OVC earmark)

Abstinence, Be Faithful/Youth (AB/Y) Reporting Requirement: If AB/Y-programmed activities do not reach a 50 percent threshold of all sexual prevention funding, as calculated by the formula below, in any country with a generalized epidemic, S/GAC is required to report to the appropriate Congressional committees on the justification for the decision. Generalized epidemic countries which do not meet the 50 percent threshold must provide a brief written justification in FACTS Info, explaining the rationale for prevention programming decisions given the epidemiologic context, contributions of other donors, and other relevant factors.

Abstinence, Be Faithful/Youth (AB/Y) programming, formerly captured in the HVAB budget code, will now be captured by using a combination of prevention program areas and beneficiaries, which are identified in the formula below. The numerator captures those interventions that are Abstinence, Be Faithful/Youth (AB/Y) programming, and the denominator approximates all sexual prevention activities. The proportion of Abstinence, Be Faithful/Youth (AB/Y) programming as a proportion of all sexual prevention activities is calculated by dividing the numerator by the denominator:

Numerator

Prevention: primary prevention of HIV and sexual violence

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, and boys)

+

Prevention: community mobilization, behavior, and norms change

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, boys, adults, not disaggregated)

Denominator

Prevention: primary prevention of HIV and sexual violence (all populations)

+

Prevention: community mobilization, behavior, and norms change (all populations)

+

50 % Prevention: Not disaggregated (all populations)

Gender Based Violence (GBV): Each OU's COP/ROP 2021 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total **new FY 2022** funding programmed to the GBV cross-cutting code. Your COP/ROP 2022 earmark is derived by using the final

COP/ROP 2021 GBV earmark allocation as a baseline. The COP/ROP 2022 planned level of new FY 2022 funds for GBV can be above this amount; however, it cannot fall below it.

Water: Each OU's COP/ROP 2021 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total **new FY 2022 funding** programmed to the water cross-cutting code. Your COP/ROP 2021 earmark is derived by using the final COP/ROP 2021 water earmark allocation as a baseline. The COP/ROP 2022 planned level of new FY 2022 funds for water can be above this amount; however, it cannot fall below it.

Initiative Controls: Table 3 shows initiative controls where S/GAC has directed funding for a set of activities that cannot be accounted for through program areas and/or beneficiaries alone. These controls can be exceeded without a control change, but a control change would be required before a lower level for these activities can be planned.

The four initiative controls below (**Cervical Cancer, DREAMS, OVC (non-DREAMS), and VMMC**) have been assigned to the appropriate OUs. For OUs where these controls are designated in the PLL, the amounts reflect the minimum required. These initiative controls can be exceeded without a control change, but a control change request would be required before a lower level for these activities can be planned.

Cervical Cancer - This initiative provides funding for all activities related to cervical cancer screening and diagnosis and treatment of precancerous cervical lesions for women living with HIV as outlined in the COP Guidance.

DREAMS - The DREAMS initiative should capture all funding specifically allocated as DREAMS in the OU's planning level and must be used for the goal of HIV and sexual violence prevention among adolescent girls and young women (AGYW) ages 10-24 years (unless otherwise approved) in approved DREAMS SNUs in accordance with the DREAMS and COP Guidance. The DREAMS initiative can also include prevention interventions in DREAMS geographic areas for girls and boys aged 10-14 which may be cost shared with the OVC (non-DREAMS) initiative as noted in the COP guidance.

OVC (non-DREAMS) - OVC (non-DREAMS) is a new initiative in COP/ROP 2022. OUs should use the initiative to budget for OVC (non-DREAMS) programming, including all OVC comprehensive activities as outlined in the COP Guidance. The OVC (non-DREAMS) initiative should include ASP, SE, and PREV costs (except PrEP and VMMC) linked to any OVC beneficiary (including sub-beneficiaries such as OVC caregivers). As the initiative is new for COP/ROP 2022, OUs should pay particular attention to funds programmed under OVC (non-DREAMS) to ensure that the current cohort of children enrolled in the comprehensive program receive continuity of care for FY 2023. The OVC (non-DREAMS) initiative can also include prevention interventions for girls and boys aged 10-14 which may be cost-shared with the DREAMS initiative as noted in the COP guidance. The OVC (non-DREAMS) initiative cannot be met with any HTS, C&T, PM or commodities costs.

VMMC - All services and equipment related to providing surgical and ShangRing VMMC for boys/men ages 15 and above, and ShangRing circumcision only for boys aged 13 and 14 years, should be budgeted using the VMMC initiative.

While the CLM initiative does not appear in PLL budget tables, as CLM remains a requirement in COP/ROP 2022 for all OUs, each OU is responsible for programming a portion of funds under the **Community-Led Monitoring** initiative.

Community-Led Monitoring - During COP/ROP 2020, PEPFAR invested in expansion of community-led monitoring, making it a requirement of all OUs, as a critical way to listen to community voices in assessment of program quality and design of client-centered services. Community-led monitoring remains a requirement in FY 2023.

In addition to the five initiatives above, S/GAC may also allocate funding to OUs under two additional initiative controls: **Condoms (GHP-USAID Central Funding)** and **One-Time Conditional Funding**. If the OU was designated to receive funding under either one or both these initiatives in COP/ROP 2022, Table 3 will reflect these amounts. Unless otherwise noted, country teams should meet these funding controls when programming in their FAST.

Condoms (GHP-USAID Central Funding) - This initiative control denotes the amount of GHP-USAID central funding the country team may use to procure male and female condoms, lubricants, and to ship these commodities to the OU. Any additional condoms and lubricants to be procured with PEPFAR funding should be budgeted in the FAST with bilateral funding.

USAID Southern Africa Regional Platform - This initiative is for the country's share of the costs to operate the USAID Southern Africa Regional Platform, which provides administrative and technical support for Angola, Botswana, Eswatini, Lesotho, and Namibia. These funds were previously planned as part of the bilateral COP funding, but are now budgeted and notified centrally, with country amounts included as central funding in the overall COP levels for Angola, Botswana, Eswatini, Lesotho, and Namibia. Only these 5 countries may use this initiative, and this initiative can only be used with central funding specifically provided as part of the PLL controls.

One-Time Conditional Funding - The release of any funding made available under this initiative is contingent upon the OU's ability to meet all requirements outlined in their final COP/ROP approval memo. OUs that fail to meet these minimum standards may be ineligible to receive these funds for programmatic implementation in FY 2023.

No control is set in the PLL for the **HBCU Tx** and **Surveillance and Public Health Response** initiatives, but OUs may include relevant funds under these initiatives instead of Core Program as appropriate.

All funding not attributed to one of the nine COP/ROP 2022 initiatives above should be attributed to the **Core Program** initiative.

For additional details on initiatives, see the [PEPFAR Financial Classifications Reference Guide](#).

Programmatic Controls: Table 4 shows programmatic controls where S/GAC has directed funding for certain programmatic activities. These controls can be exceeded without a control change, but a control change would be required before a lower level for these activities can be planned. Since every dollar programmed in COP must belong to one initiative, programmatic controls will be a subset of one or more initiative controls, even if the standard Core Program initiative.

PrEP (AGYW) - The PrEP (AGYW) programmatic control tracks all funding budgeted under the Prevention – PrEP program area and sub-program area for the Females – Adolescent Girls and Young Women sub-beneficiary. The control encompasses both service delivery (SD) and non-service delivery (NSD) activities, inclusive of any commodities costs. OUs should tailor the distribution of funds to SD and NSD based on the country context prioritizing the provision of PrEP services and increasing the

number of AGYW on PrEP wherever possible. Countries with a PrEP (AGYW) control should expect to program no more than 10 to 30 percent of their control as non-service delivery.

PrEP (KPs) – The PrEP (KPs) programmatic control tracks all funding budgeted under the Prevention – PrEP program area and sub-program area for all sub-beneficiaries under the KP beneficiary. The control encompasses both service delivery (SD) and non-service delivery (NSD) activities, inclusive of any commodities costs. OUs should tailor the distribution of funds to SD and NSD based on the country context prioritizing the provision of PrEP services and increasing the number of KPs on PrEP wherever possible. Countries with a PrEP (KPs) control should expect to program no more than 10 to 30 percent of their control as non-service delivery.

State ICASS: Table 5 shows the amount that the OU must program under State for ICASS Costs.

Funds Programmed under State/SGAC (S/GAC TBDs)

No funding may be programmed under State/SGAC without prior approval from S/GAC M&B. In general State/SGAC TBDs are only used in extraordinary and or unusual circumstances. To the degree that funding is approved, the rationale and any conditions attached to the funding will be documented by M&B. Any S/GAC TBDs approved during COP/ROP 2022 planning will require supplemental language in the OU's COP/ROP 2022 approval memo, clearly outlining the process for how these funds can be accessed. Any funds that have not been distributed to agencies before the end of FY 2023 may be subject to reprogramming in future planning cycles towards the same OU or another OU.

COP/ROP 2022 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)

Whenever possible, all agencies within an OU should hold several months of pipeline at the end of COP/ROP 2022 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. If an agency/OU combination has a history of over-outlays, or in cases where an agency/OU COP envelope has increased in recent years, there may not be sufficient funding to maintain this buffer. With the exception of Dominican Republic, Ethiopia, Haiti, South Sudan, Zimbabwe, Asia Regional Program, and Western Hemisphere Regional Program, which should hold up to four months of pipeline, all other OUs are permitted to hold no more than three months of buffer pipeline.

Any agency that anticipates ending COP/ROP 2021 implementation (end of FY 2022) with a pipeline in excess of three or four months is required to apply this excessive pipeline to COP/ROP 2022, decreasing the new funding amount to stay within the planning level.

Transitioning HIV Services to Local Partners

To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. In COP19 Guidance, PEPFAR set a goal that 40% of partners must be local by the end of FY19, and 70% by the end of FY20. While considerable progress was made in this effort, the 70% mark was not achieved by all agencies in all OUs, and thus in FY22 and FY23, teams must continue to prioritize this so that the 70% goal can be realized. Each country has to contribute to this goal based on the context of the local partner

mix and types of public and private partners available to provide essential services. Therefore, each OU agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY23 as appropriate through their COP/ROP 2022 submission.